DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G203	A. BUILDING _____ B. WING _____	C 07/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC	6010 DIX STREET, NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS On July 7, 2008 at approximately 7:45 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that Active Treatment Specialists (ATS) #1 witnessed ATS #2 squeezing Client #1's right hand and mouth. The SA conducted an on-site investigation on July 10, 2008 to verify compliance with the basic standards of practice and federal participation requirements in the Conditions of Governing Body and Client Protection. The investigation determined that ATS #2 was placed on administrative leave on July 7, 2008 at approximately 1:42 PM. The facility's internal investigation substantiated the allegation of abuse and ATS #2 has been scheduled to be terminated from employment. The results of the investigation were based on interviews with Client #1, ATS, nursing and administrative staff. Also the findings were based on the review of the client's medical record, and the facility's administrative records; including incident reports.	W 000	Received 8/20/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the governing body exercised general policy and operating direction over the facility, except in the following areas:	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADRS (X6) DATE 8/20/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 The finding includes: Cross refer to W149. The governing body failed to provide sufficient administrative oversight to ensure the implementation of its incident management policy involving reporting all allegations of abuse immediately to the administrator.	W 104	**W104** **This standard will be met as Evidenced by:** **Review of record indicates that The facility currently has written policies and procedures regarding abuse/neglect and mistreatment.** **A team efforts has been utilized by the senior management (Director of Residential Services, Assistant Director, Director of nursing, RN's Incident Manager and Training Department) to retrain all staff in the area of abuse/neglect, incident reporting and Bill of right.** **The facility will ensure that all incidents are reported to pertinent agency/management in accordance with district law and that confirmation report is file on client record/incident report book.** **The facility management/Training department will continue to train staff on an on-going basis and will ensure all incident of abuse/neglect or mistreatment are thoroughly investigated in accordance with standard. Any employee that fails to comply with this standard as set forth will be subject to disciplinary action.**	7/10/2008
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's staff failed to implement it's incident management protocol for one of one client in the investigation (Client #1). The finding includes: On July 9, 2008 at approximately 4:00 PM an Unusual Incident Report (UIR) dated July 7, 2008, was reviewed and revealed that Active Treatment Specialists (ATS) #1 reportedly witnessed ATS #2, physically abusing Client #1 by squeezing Client #1's right hand and mouth on July 7, 2008. Interview with the Licensed Practical Nurse (LPN) on July 10, 2008 at approximately 2:00 PM revealed that approximately between the hours of 6:00AM and 6:15AM on July 7, 2008, ATS #1 informed her that ATS #2 was "fighting" Client #1. The LPN statd that she assessed Client #1 and that she did not discover any swelling, scratches or bruises to Client #1's right hand or mouth.	W 149		

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W 149	Continued From page 2 Further interview revealed that on July 7, 2008, the the LPN did not report the alleged abuse involving Client #1 to anyone . Interview with ATS #1 on July 11, 2008 at approximately 6:45AM revealed that she witnessed ATS #2, physically abuse Client #1 by squeezing Client #1's right hand and mouth. ATS #1 stated that on July 7, 2008, she informed the LPN and the ATS shift leader of the incident. Further interview revealed that ATS #1 did not report the alleged abuse involving Client #1 until 9:00AM on July 7, 2008. At that time she reported the alleged abuse to the Facility Coordinator (FC). Interview with the ATS Shift Leader on July 11, 2008 at approximately 7:50 AM revealed that on July 7, 2008 at approximately 6:00 AM when she arrived on duty, ATS #1 requested that she come and observe ATS#2 "beating up" Client #1. The ATS Shift Leader stated that she did not witness ATS #2 physically abusing Client #1. The ATS Shift Leader stated she cheked Client #1's body and that Client #1was not observed to have any bruises on her body. Further interview revealed that on July 7, 2008, the ATS Shift Leader did not report the alleged abuse involving Client #1 to anyone . Review of the Incident Management Policy dated July 1, 2003 on July 14, 2008 at approximately 4:40 PM revealed that "any person who witnesses, discovers or is informed of a Serious Reportable Incident as defined by this policy, must immediately verbally report the incident to the immediate supervisor/manager on duty. The facility staff on duty will accept reports of Serious Reportable Incidents, on a 24 hour, 7 days a week basis."	W 149	**W149** **This Standard will be met as Evidenced by:** All staff received training on July 10, 2008. In addition, facility management will continue to train staff in an on-going basis to ensure compliance with incident reporting procedures as written.	7/10/2008

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W 149	Continued From page 3 There was no evidence that the facility's ATS and nursing staff implemented it's incident management policy in a timely manner.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that all allegations of abuse are reported immediately to the administrator. The finding includes: Cross refer to W149. On July 7, 2008 at approximately 7:45 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that Active Treatment Specialists (ATS) #1 witnessed ATS #2 squeezing Client #1's right hand and mouth. The incident of alleged abuse was not reported to the administrator or to the SA immediately.	W 153	**W153** **This standard will be met as evidenced by:** **Disciplinary action has been given to the employees involved in failure to report incident as outline in the policies and procedures.** **In addition, staff has received additional training in the areas of policies and procedures as outlined by the agency and DDS.** **The facility management/Training department will continue to reinforce this policy by providing on-going training in this area.** **Evidence of such training will be filed inside the training book in the facility.**	8/20/2008
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		

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W 159	Continued From page 4 This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate the health and safety needs for one of one client in the investigation. (Client #1) The findings include: 1. Cross refer to W153. The QMRP failed to ensure that Active Treatment Specialists (ATS) and nursing reported all allegations of abuse, immediately to the administrator. 2. Cross refer to W189. The QMRP failed to ensure that ATS and nursing staff received continuing training to enable them to implement the facility's incident management policy on reporting all allegations of abuse immediately to the administrator.	W 159	**W159** **This Standard will be met as Evidenced by:** **The QMRP/Director of nursing ,incident manager and training department has complete training of all staff to ensure that all direct care staff /nurses are trained in areas of incident reporting, abuse/neglect and individual bill or rights.** **In addition, The QMRP will also ensure that direct care staff receives adequate training to perform duties effectively, efficiently and competently.**	7/10/2008
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The finding includes: Cross refer to W149. The facility staff had not been effectively trained to implement the facility's	W 189		

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W 189	Continued From page 5 incident management policy on reporting all allegations of abuse immediately to the administrator.	W 189	**W189** **This Standard will be met as Evidenced by:** **Cross Reference W149**	7/10/2008

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I 000	INITIAL COMMENTS On July 7, 2008 at approximately 7:45 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that Active Treatment Specialists (ATS) #1, witnessed ATS #2, squeezing Resident #1's right hand and mouth. The SA conducted an on-site investigation on July 10, 2008 to verify compliance with the State licensure regulatory requirements. The investigation determined that ATS #2 was placed on administrative leave on July 7, 2008 at approximately 1:42 PM. The facility's internal investigation substantiated the allegation of abuse and ATS #2 has been scheduled to be terminated from employment. The results of the investigation were based on interviews with Client #1, ATS, nursing and administrative staff. Also the findings were based on the review of the client's medical record, and the facility's administrative records; including incident reports.	I 000	Received 8/20/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.	I 379		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE AURS (X6) DATE 8/20/08

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I 379	Continued From page 1 This Statute is not met as evidenced by: GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. The finding includes: On July 9, 2008 at approximately 4:00 PM an Unusual Incident Report (UIR) dated July 7, 2008, was reviewed and revealed that Active Treatment Specialists (ATS) #1 reportedly witnessed ATS #2, physically abusing Resident #1 by squeezing Resident #1's right hand and mouth on July 7, 2008. Interview with the Licensed Practical Nurse (LPN) on July 10, 2008 at approximately 2:00 PM revealed that approximately between the hours of 6:00AM and 6:15AM on July 7, 2008, ATS #1 informed her that ATS #2 was "fighting" Resident #1 1. The LPN statd that she assessed Resident #1 and that she did not discover any swelling, scratches or bruises to Resident #1's right hand or mouth. Further interview revealed that on July 7, 2008, the the LPN did not report the alleged abuse involving Resident #1 to anyone . Interview with ATS #1 on July 11, 2008 at approximately 6:45AM revealed that she witnessed ATS #2, physically abuse Resident #1 by squeezing Resident #1's right hand and mouth. ATS #1 stated that on July 7, 2008, she informed the LPN and the ATS shift leader of the incident. Further interview revealed that ATS #1	I 379	**3519.10** **This Statue will be met as evidenced by:** **Cross Reference W104, W149, W153 and W159**	**7/10/2008**

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I 379	Continued From page 2 did not report the alleged abuse involving Resident #1 until 9:00AM on July 7, 2008. At that time she reported the alleged abuse to the Facility Coordinator (FC). Interview with the ATS Shift Leader on July 11, 2008 at approximately 7:50 AM revealed that on July 7, 2008 at approximately 6:00 AM when she arrived on duty, ATS #1 requested that she come and observe ATS#2 "beating up" Client #1. The ATS Shift Leader stated that she did not witness ATS #2 physically abusing Resident #1. The ATS Shift Leader stated she cheked Resident #1's body and that Resident #1 was not observed to have any bruises on her body. Further interview revealed that on July 7, 2008, the ATS Shift Leader did not report the alleged abuse involving Resident #1 to anyone . Review of the Incident Management Policy dated July 1, 2003 on July 14, 2008 at approximately 4:40 PM revealed that "any person who witnesses, discovers or is informed of a Serious Reportable Incident as defined by this policy, must immediately verbally report the incident to the immediate supervisor/manager on duty. The facility staff on duty will accept reports of Serious Reportable Incidents, on a 24 hour, 7 days a week basis." There was no evidence that the facility's ATS and nursing staff implemented it's incident management policy in a timely manner.	I 379		